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An exploration of high school Principals' and Assistant Principals' perceptions of implementing mental health curriculums in schools

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An Exploration of High School Principals' and Assistant Principals' Perceptions of Implementing Mental Health Curriculums in Schools

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Abstract

Mental health literacy is one's knowledge of mental health conditions and their accompanying symptoms as well as their understanding of available treatments and mental health services. Virginia Bill SB953, signed into law in 2018, made mental health a mandated topic in health education for all ninth and tenth grade students. There are several Health Education Standards of Learning for Virginia Public Schools which are specifically aimed at increasing students' mental health literacy. Many of the standards can be met through implementation of evidence-based curriculums focusing on mental health, known as mental health curriculums (MHC). MHC are designed to increase mental health literacy. The purpose of the present study was to explore high school principals and assistant principals' perceptions and experiences with implementing MHC in their schools. The results will be used to inform school psychologists on current practices in regard to MHC, as well as provide information on how to collaborate with school principals to make implementation of MHC more realistic.

Keywords: mental health literacy, mental health curriculum, mental health education, adolescent mental health, psychoeducation in schools, school-based mental health, school mental health service

Introduction

Mental health has become a public health crisis. According to the National Survey of Children's Health, conducted by the Center for Disease Control (CDC), approximately 7.1% (4.4 million) of children aged 3-17 years old have diagnosed anxiety, while 3.2% (1.9 million) have diagnosed depression (Center for Disease Control, 2019). The first signs of most mental health conditions begin to show during childhood and become more prevalent during and throughout adolescence (Skre et al, 2013). In fact, roughly half of mental health conditions start by mid-teens or have their onset before the age of 20 (Salerno, 2016; Stagman & Cooper, 2010). Despite the increasing prevalence, research suggests that adolescents have difficulty recognizing common mental health conditions and the associated symptoms (Orsson & Kennedy, 2010).

Mental health literacy, or public knowledge and beliefs about mental conditions, is crucial for early recognition of mental health illnesses and appropriate help-seeking (Olsson & Kennedy, 2010; Skre et al., 2013). Mental health literacy encompasses several different factors: recognition of general psychological distress and specific mental conditions, knowledge and beliefs about risk-factors, self-help interventions and available professional help, attitudes that facilitate appropriate help-seeking, and ability to seek mental health information (Jorm, Barney, et al., 2006; Olsson & Kennedy, 2010). Put simply, mental health literacy is one's knowledge of mental health conditions and their accompanying symptoms as well as their understanding of available treatments and mental health services. The value of mental health literacy has been acknowledged as a priority for youth, with mandates for mental health education for students in high school. Virginia and New York were the first two states to mandate mental health education in 2018, with many states following over the course of the last two years.

Prior to the development of this research, the researcher originally planned to conduct an entirely different study. The goal was to implement a specific mental health curriculum at a local high school and analyze several different variables, including students' mental health literacy and the value of mental health education. With mental health being a mandated topic in health education for all ninth and tenth grade students in Virginia, the researcher expected the response to the curriculum to be overwhelming positive and assumed implementation would be a smooth process, with possibly a few complications along the way. However, gaining approval to implement the curriculum at a high school proved to be much more difficult than was expected.

The principals, as well as the directors of health education and special education, who were approached about the previous study were very on-board with the *idea* of implementing a mental health curriculum, however actually implementing the curriculum began to seem impossible after the researcher encountered one obstacle after another. Ultimately, the study could not be conducted due to school closures related to COVID-19. Due to the many obstacles experienced when trying to implement the original study and a desire to better understand the barriers and supports that are available when trying to implement a mental health curriculum (MHC), the current study was initiated.

Adolescent Mental Health

Good mental health is vital for students' academic well-being and success in schools. Mental health conditions, such as depression and anxiety, can affect students overall academic experience and performance in a number of ways. According to the National Association of School Psychologists (NASP), when students' mental health needs are left unmet, they are more susceptible to negative outcomes such as academic and behavior problems, dropping out, and delinquency (2015). Children and adolescents with untreated mental health conditions have

lower educational achievement than their peers. In high school specifically, students with mental health conditions are more likely to fail or drop out of school (Stagman & Cooper, 2010).

Students with depression are more likely than their peers to have difficulty concentrating, completing assignments, paying attention, achieving at grade level, feeling academically competent, persisting on tasks, and feeling motivated to perform (Huberty, 2010). Finning and colleagues (2019) conducted the first and only systematic review and meta-analysis of child and adolescent depression and poor attendance at school. The study found a positive association between depression and school refusal, suggesting that depression is associated with poor attendance at school. Symptoms associated with depression such as social withdrawal, loss of motivation, sleep disturbance, and reduced energy, may impact a child's ability to regularly attend school. Socially, students with depression are more likely to be withdrawn and derive less enjoyment from their surroundings. They may appear uninterested or unmotivated in school. School personnel and other students may feel that a student with depression is deliberately choosing to act this way, however this is not the case.

Without receiving proper treatment, depression may escalate into suicidal ideation. Depression is the most serious risk factor for suicide, which is currently the second leading cause of death for youth and adolescents ages 10-24 and is the leading cause of death among school-age youth (NASP, 2015). There is a clear link between depression and suicide. In fact, the risk of suicide is much higher for depressed students than for their non-depressed peers (Stagman & Cooper, 2010). Students with depression generally want to do well in school and succeed academically, but without intervention they lack the ability and motivation to do so independently. Support for mental health conditions is associated with better overall well-being and academic performance (Weisman, Kia-Keating, Lippincott, Taylor, & Zheng, 2016). NASP

has stated that students who receive appropriate mental health support do better academically (2015).

Adolescent Mental Health Literacy

Most children and adolescents in need of mental health services (75% to 80%) do not receive them (Stagman & Cooper, 2010). Findings from a study aimed at examining national trends in the prevalence, risk factors, and treatments of depression in adolescents revealed that within recent years there has been a growing number of adolescents with untreated major depression (Lu, 2019). Though depression is a treatable mental health condition, the current research suggests that adolescents know very little about it, the accompanying symptoms, or how to appropriately seek help or treatment when experiencing symptoms (Jorm, Korten, et al., 1997; Jorm, Barney, et al., 2006). Data from a study done to assess adolescents' knowledge of depression (Hess et al., 2004) found that students' knowledge about depression was limited. Symptom recognition is a crucial piece of mental health literacy, as adolescents need to know symptoms of a disorder in order to be able to identify it. Notably, when asked to 'list 5 symptoms of depression,' less than half of the participants were only able to list three or fewer symptoms of depression. According to the Diagnostic and Statistical Manual of Disorders, Fifth Edition (DSM-5), a diagnosis of depression requires the presence of five or more symptoms for two weeks or longer (2013). Thus, adolescents need to know the symptoms to aid in recognition of the illness in themselves or a peer. Alarmingly, almost half of the total sample in the study indicated that they believed that depression can be controlled through willpower.

In another study aimed at assessing the mental health literacy of 16-year-olds, specifically in regard to their knowledge of depression (Burns & Rapee, 2006), the researchers found that students had a mixed level of knowledge in their ability to identify and label depression and the

key symptoms of the condition. Students were asked to look at different vignettes depicting young people going through a range of life difficulties. In response to the two 'depressed' vignettes, students were more able to recognize and label depression for the vignette which included comments of suicidal intent and feelings of worthlessness than they were for the one that lacked such obvious symptoms. The results suggested that for adolescents, the combination of presenting symptoms and the context in which they are presented may be important.

Limited mental health literacy, the stigma surrounding mental health and seeking treatment, and even social discrimination have been shown to be factors that prevent adolescents from seeking support when experiencing mental health symptoms (Jorm, Korten, et al., 1997; Rickwood, Cavanagh, Curtis, & Sakrouge, 2004; Perry et. al, 2014). Without the knowledge or understanding of mental health conditions and the accompanying symptoms, adolescents are not able to recognize the conditions or symptoms in themselves or in a peer. This makes it unlikely they will seek mental health support for themselves or suggest it for a peer.

Lack of knowledge of mental health conditions can contribute to stigmatizing attitudes as well. Unfortunately, this can create a vicious cycle and further contribute to a misunderstanding of, and stigmatizing beliefs towards, students with mental health needs. In a study done by Skre et al. (2013), they found that while a universal school intervention increased adolescent mental health literacy, stigma functioned as a buffer against gaining knowledge about where to seek appropriate mental health support. In other words, negative attitudes towards mental health or stigmas negatively impacted students' ability to increase their mental health literacy. Additionally, children with stigmatizing attitudes have been found to exclude peers who they believe to have a mental health condition (Weisman et al., 2016).

The current literature suggests that schools are the primary setting where children and adolescents seek and receive mental health support when they are treated (Swartz et al., 2017). This makes school the ideal place for mental health prevention and treatment services, such as implementation of MHC's, which are designed to increase students understanding of mental health.

Mental Health Curriculums in Schools

Nearly 60% of students do not receive the mental health support they need, and of those who do, they do so only in school (NASP, 2015). School psychologists are qualified mental health professionals within school systems who are specially trained to work with youth dealing with academic, social, emotional, and behavioral difficulties. As such, school psychologists are in a primary position to help youth in need of mental health education. One way this this can be done is by implementing school-based mental health intervention and prevention programs, such MHCs. Specifically, curriculums that focus on increasing mental health literacy have been shown to increase students' ability to not only correctly recognize mental health symptoms, but to also increase their efforts to seek early care or treatment for such symptoms (Swartz et al., 2017).

In order to meet the mental health needs of adolescents with major depression, psychoeducation is warranted (Lu, 2019). Comprehensive mental health services are best served to students through a multitiered system of supports (MTSS). Mental health curriculums taught at the universal level allow school systems to promote mental wellness among all students as well as address and identify mental health problems before they escalate. Schools are an optimal setting for implementation of such programs, as they are the place where adolescents spend most of their time (Fazel, Hoagwood, Stephan, & Ford, 2014).

Mental health programs in schools have the potential to increase students' overall mental health literacy (Rickwood et al, 2004; Perry et al, 2014). Results from the first study done to evaluate the effectiveness of a mental health literacy intervention given to high school students, specifically looking at knowledge and stigma, found the school-based program to be very effective in increasing both knowledge and positive attitude towards mental health (stigma). Not only was the intervention successful at increasing student's mental health literacy and reducing stigma towards mental health, the researchers found a strong, positive correlation between the two variables, suggesting that increases in knowledge significantly predict an increase in positive attitudes towards mental health (Milin et al., 2016). In addition, universal programs allow the opportunity to benefit a large number of students who may not currently be symptomatic, but could be in the future (Swartz et al., 2017).

Findings from multiple studies suggest that mental health programs in schools may help with reducing stigmatizing attitudes (Rickwood et al, 2004; Weisman et al, 2016). There is also some evidence to suggest mental health programs improve adolescent help-seeking behavior, while some studies have found the opposite. Rickwood et al. found that a mental health program had a strong impact on knowledge, a moderate impact on stigma reduction, and a weak impact on help-seeking behavior (2004). Perry et al. (2014) researched another mental health program and found similar results. The program also improved mental health literacy and decreased stigma but did not have a significant impact on adolescent attitudes towards help-seeking. On the other hand, Swartz et al. (2017) found that addition of a mental health curriculum to the standard high school education curriculum resulted in significantly higher levels of depression literacy, as well as increased help-seeking behavior. However, this program did not have an effect on mental health stigma.

A common theme among the researched mental health curriculums or programs is that they tend to look at mental health literacy and increase in knowledge, help-seeking behavior, and stigma, sometimes referred to as positive attitudes. Research currently suggests that MHC tend to positively impact mental health literacy and help-seeking behavior, while evidence relating to stigma reduction has been mixed.

Mental Health Literacy in Virginia

In Virginia, mental health is a mandated topic in health education, for all ninth and tenth grade students. There are several Health Education Standards of Learning for Virginia Public Schools in regards to mental health literacy. For example, by the end of ninth grade, all Virginia students are expected to "identify signs and symptoms of depression, risk factors for suicide, and risk factors for other self-destructive behaviors" (Standard of Learning 9.1.N). By the end of tenth grade, students are taught to "describe when to seek support for self and others, and role-play various help-seeking strategies" (Standard of Learning 10.3.R)

While the Virginia Department of Education (VDOE) website does provide sample plans and resources for each area of instruction, including Social Emotional, which is what mental health education is categorized under, many of them appear to be very arbitrary in nature, which leaves a lot of interpretation up to each individual instructor. Additionally, there are objectives provided at the beginning of each unit, however there does not appear to be a way to assess whether or not the objectives have been met at the end of each unit. However, many of the standards related to mental health could be met by through implementation of evidence-based curriculums focusing on mental health.

A study looking at mental health literacy among young people at a small school in Virginia found that recognition of mental disorders, including depression, were low.

Encouragingly, of those who were able to recognize and label a disorder, they were three to four times more likely than those who were unable to say they would take some type of helping action (Olsson & Kennedy, 2010). These results suggest that increased knowledge of, and ability to, recognize mental health conditions increases the likelihood adolescents will seek help when they or a friend are experiencing symptoms. Students in this study were also asked if they had discussed mental health in their health or PE classes in the past 12 months. Despite the fact that in Virginia, mental health is a mandated topic in health education, only 27.7% of students reported they had discussed mental health in Health or PE class.

Another study that investigated adolescent mental health literacy, conducted at a school in Central Virginia, found that diminished ability to think/concentrate and fatigue/loss of energy were the symptoms of depression students were least able to recognize (Meeks, 2018). A study conducted by Rice et al. found that vegetative/physical symptoms were more common in adolescents, including loss of energy, change in weight, appetite, and sleep changes (2019). Experiencing one or many of these symptoms, especially throughout the school day, could negatively impact academic performance and student success. The results from Meeks (2018) study of also found that adolescents are more likely to highly regard informal sources of help. This finding suggest it is important to educate adolescents on appropriate sources of help and when seeking formal help may be more appropriate.

There is information to suggest that students may benefit from interventions aimed at increasing their mental health literacy. Students would benefit from discussions and lessons in school aimed at improving their understanding of mental health conditions and symptoms. In addition, students should be informed of local and community mental health centers and taught how to appropriately seek out these services.

Purpose

The purpose of the present study was to add to the limited literature on accessibility of, and barriers to, implementing mental health curriculum's in high schools through the perspectives of school principals and assistant principals. To the researcher's knowledge, this is the first study conducted which solely focused on the experiences of principals and vice principals with mental health curriculum implementation at the high school level. In addition to examining the current practices of mental health implementation at the high school level, the information gathered from this study will be used to help inform school psychologists on how to have conversations with principals and assistant principals regarding mental health curriculums. The present study examined the responses of high school principals and vice principals in order to address the following research questions:

1. What are the current practices for implementing Mental Health Curriculum's (MHC) in schools based on high school principals' perceptions?
2. What is the interest level of high school principals in implementing MHC?
3. What facilitates or supports implementation of MHC in schools based on high school principals' perceptions?
4. What are the challenges to implementing MHC in schools based on high school principals' perceptions?

Methods

Participants

Participants included three current high school principals and two current assistant principals, for a total of 5 participants. Principal 3 and Principal 4 work at the same school. The subject pool pulled from sites geographically dispersed across the state of Virginia, representing a broad spectrum of different school systems and their resources and needs. No other information about the participants or their schools was collected for the purposes of this study.

Measure

An 8-item, semi-structured interview was created for this study. Interview questions are listed in Appendix A. The questions were designed by the researcher to address the research questions specific to this study. Participants were asked a series of questions in regard to current implementation processes, if any, of mental health curriculums in their schools.

Procedure

This study was approved by the James Madison University Institutional Review Board. Convenience sampling was used to identify participants. Two potential participants, known to the researcher, were contacted by the researcher individually and asked to participate. Both principals responded and agreed to participate in the study, however due to scheduling constraints, only one participated. The researcher also sent a short ad/script via email to professional contacts (Appendix B). The ad/script was sent to 30 professional contacts. The professional contacts then sent the ad/script to potential participants. Potential participants were asked to share their email address if they wanted to be contacted to participate in the study. Six email addresses were provided to the researcher. The researcher then reached out to each principal individually via email to set up a date and time for a 20-minutes phone interview. Three

out of the six potential participants responded and scheduled interviews. One of the participants provided the researcher with the email address of an assistant principal at their school. The researcher then reached out and scheduled an interview with the assistant principal as well.

On the scheduled date, at the agreed upon time, the researcher called the participant. Verbal consent was read aloud to each participant by the researcher. Consent to audio record the interview was also obtained. Upon completion of the interview, each audio recording was transcribed and immediately destroyed thereafter.

Data Analysis

All interviews were audio recorded for the purposes of transcription and coding purposes. It was important to the researcher to try to capture the ideas, opinions, and experiences of the participants and thus qualitative analysis was used. To identify themes that emerged from the data, the 'cut and sort' process, was used (Taylor-Powell and Renner 2003). The analysis focused on how participants responded to each question and whether any themes, consistencies, or differences existed across responses. Additionally, the researcher looked for overarching themes that existed throughout the interviews and any connections or relationships between questions. Most of the responses to the interview questions contained one or two “main themes” that were then broken down into “sub themes” if necessary. The main themes and sub-themes that emerged from each question are presented in the results section below. Further analysis of themes and sub-themes, as well as, specific quotes provided by each respondent are presented in the discussion section.

Results

Interview Question 1

Interview Question 1 asked “What mental health curriculum(s), if any, does your school implement?”. The purpose of this question was to address Research Question 1: 'What are the current practices for implementing Mental Health Curriculum's (MHC) in schools based on high school principals' perceptions?'. All respondents stated that they are not currently implementing a MHC in their schools. For this question, participants often discussed other ways in which mental health is discussed with students or incorporated throughout their school, outside of utilization of a MHC. While none of the participants are actively using a MHC, their responses indicated mental health education may occur through specific courses offered. Principal 5 specifically mentioned Freshman Seminar and Health/PE. Principals also discussed how mental health may be addressed through school-wide initiatives that focus on social-emotional learning, like PBIS. Interestingly, when participants discussed mental health, responses were very surface-level and did not indicate that these activities truly focus on, or increase, mental health literacy. Principal 1 discussed how most of the mental health and social-emotional programs are tied into their PBIS program, while Principal 2 mentioned that mental health is addressed during the health component of the school’s physical education. Similarly, Principal 4 replied, “Outside of the mental health curriculum that our 9th and 10th graders receive, which is limited from their Health/Physical Education class, we do not have a mental health curriculum that’s really implemented here in our building.”

Participants were open and honest with their responses, with some even admitting that the mental health programming and education opportunities at their school are dated or lacking entirely. Principal 3 replied, “Okay. So, we don’t have an actual store-bought curriculum that

each teacher is expected to implement in the classroom. What we do have, this year, we started what's called Sources of Strength program.", which is a program that models multiple sources of support, one being mental health.

Another variable that was prominent when analyzing the responses to this question, was the verbiage used by participants when discussing curriculums, specifically mental health curriculums. Participants often noted that the material or lessons used to discuss mental health are not "intentional" or referred to as a mental health curriculum. Some participants indicated information about mental health may be "piecemealed" together with the information and resources that are available. There was no mention at all of an evidence-based curriculum.

Interview Question 2

Interview Question 2 asked, "How have you worked with staff to implement mental health curriculums in your school?". This question was designed to capture each principal's level of involvement with staff in regard to implementation of mental health curriculums at their schools and provide additional information to address Research Question 1. Since none of the participants stated that they are actively using a MHC, they were asked to describe their involvement regarding other mental health programming or school-wide initiatives as a follow-up to their response from Question 1. Responses were coded into 'Moderately or Very Involved' (n = 2) and 'Minimally or Not Involved' (n = 3).

This terminology was used because the level of involvement of each principal was not explicitly clear based on their responses and level of involvement seemed to exist on a spectrum. For example, despite being asked to reflect on personal involvement, one principal responded by sharing his experience in plural form "When we target some of our student's with disabilities, we focus on addressing bullying, coping mechanisms…". While the respondent mentioned how

mental health is being addressed at their school and provided examples, it was not clear what the actual involvement or role of the principal was and was thus coded as 'Minimally or Not Involved.' Responses were coded 'Minimally or Not Involved' if the participant's response implied they had little involvement or if the participant was unclear about their specific role or involvement. Responses were considered 'Moderately or Very Involved,' if a participant went into detail about different activities or programs offered, as well as included a description of their personal role in regard to said activities.

Principal 3 seems to be very involved at their school and stated they hired an assistant principal three years ago stating, "you know, a principal is only as good as the people they surround themselves with, I truly believe that." The purpose for hiring an assistant principal was to take the lead of the social emotional learning components at their school. The assistant principal often attends conferences that focus on SEL and then will bring back ideas for the school to implement, one being "Stop It," an anonymous reporting system. Principal 3 and the assistant principal recognize that there are many different ways in which student mental health can be supported in schools. Together, Principal 3 and the assistant principal that was hired, even helped write a new policy for their school-division to allow therapy dogs in schools. Principal 4 stated "So—in regards to Health/Physical Education program, we work with our Health and Physical Education teachers and encourage them to keep up on the newest literature that's out there as well as provide them information on any type of in-services… But as far as us, administrators, working directly with the teachers—we don't work directly with the teachers for that part."

Ignoring level of involvement, oher themes that were evident among participants responses included collaboration, providing learning opportunities, and initiating systems or

building level change. Principal 1 stated they use PBIS and the Jostens Renaissance program to "truly benefit students and meet their needs in terms of academic performance, social emotional competence, social and academic outcomes."

Principal 2's experience seemed to center more around having discussions with staff from the guidance department, who then share information with teachers. They stated that guidance department at their school is considered the "resident specialist on it [mental health], even though they haven't had extensive training." They continued on to say that they believe their school is behind when it comes to mental health education and there is a need for "understanding the challenges of mental health and schools today."

Interview Question 3

Interview Question 3 asked, "Who would you contact from your school to find and implement a mental health curriculum?". This question provided information for addressing Research Question 3, 'What facilitates or supports implementation of MHC in schools based on high school principals' perceptions?'. Responses were tallied and combined to provide results for the school staff or administrative members participants reported they would seek out to find and implement a mental health curriculum. Responses included: Administration, Principal, Director of Guidance, School Counselors, Secondary Supervisor, PBIS Coordinator, Director of Pupil Services and School Psychologist.

Three of the participants reported they would reach out to multiple staff members and form a team when seeking out help for implementing a MHC, specifically Administration and Director of Guidance, whereas the participant who reported Secondary Supervisor and the participant who reported 'Director of Pupil Services,' each only stated they would reach out to the single resource stated. For example, Principal 5, who is an assistant principal, shared that

they would first communicate with the principal their desire to implement a MHC. If received well by the principal, and permission was granted to move along, Principal 5 then stated the next step would be to "use the expertise of the school counselors to generate ideas on moving forward and finding information." As an afterthought, Principal 5 began to describe how over the course of the last school year (2019-20), they worked more closely with the school psychologist than ever before. It was during these interactions, such as during school-based intervention team meetings or MDR meetings, that Principal 5 learned just how knowledgeable school psychologists are in this area. Laughing, Principal 5 added, "I've come to kind of understand just how much school psychologists really know about this stuff [mental health], that I don't."

Principal 2 stated they would contact their secondary supervisor to have them seek out a curriculum or to have somebody come and speak to the staff. They went on to say, ". I don't know that I would specifically reach out myself, but we would be looking out for guidance back from our division and possibly even the Department of Education on some type of implementation or training."

Interview Question 4

Interview Question 4 stated, "Explain any exposure you have had to specific mental health curriculums (e.g. conversations with school)". This question provided additional understanding for Research Question 1 regarding principals' perceptions for current practices for implementing MHC(s). Responses were coded into one of two groups: 'Exposure' (n=1) or 'No Exposure' (n=4). This was based on whether or not a participant explicitly stated the name of a MHC they had been exposed to. A response was coded as 'No Exposure' if the participant did not explicitly state they have had exposure to a specific MHC. In the 'No Exposure' group, one participant explicitly stated they had never been exposed to a specific MHC, while the other

three participants responded with examples of exposure they have had to mental health in general, but did not mention any kind of MHC. Principal 4 was the only participant to specifically state the name of a curriculum, Teen Health, which is their county-based, purchased curriculum that is used for 8th and 9th graders, adding, "which at this point is probably dated."

When analyzing the responses in the 'No Exposure' group, an over-arching theme was observed: 'Participation in Learning Opportunities.' Participants' responses indicated most of their exposure to mental health, within the school setting and within the context of their profession, was through learning opportunities such as professional development, reading materials and journal articles, conferences, learning modules, or conversations with staff knowledgeable on the topic of mental health, specifically the school social worker. Despite not being exposed to a specific MHC, responses indicated that participants had engaged in various kinds of learning opportunities in order to increase their awareness and understanding of mental health. A sub-theme emerged from this over-arching theme: 'Mental Health Literacy.' This was an interesting observation for the researcher, as all of the participants shared ways in which they have learned about mental health, not realizing the activities they were engaging in contributed to, and likely increased, their own mental health literacy. Principal 1 stated they often refer to the school social worker in regard to student mental health support. At their school, the school social worker works with staff to increase their mental health literacy and help them to be able to identify students who are in distress.

While Principal 2 did not state they have been exposed to a specific curriculum, they began reflecting on their experience with the mental health needs of students. They reported, "I've been in this business of administration for 15 years and I see it [mental health] being on the

rise, but the conversation comes across our table more often about how to work with students who present some of these challenges in their life."

Interview Question 5

Interview Question 5 asked "What supports or avenues do you have in your schools to help make mental health curriculums more feasible or accessible to students?". Information from this question addressed Research Question 3, 'What facilitates or supports implementation of MHC in schools based on high school principals' perceptions?. Participants most often cited their relationships with other staff members or bodies, such the school board, as supports within their school or district. All participants expressed that they rely heavily on the expertise of certain staff members, such as school counselors and school social workers or other administration, when it comes to understanding mental health. The second most common support reported by participants included current programs or courses offered in their schools that may touch on mental health in some way.

Principal 4 discussed a specific program that helps address mental wellness, stating, "While we don't have that specific boxed curriculum, Sources of Strength does allow for teachers and students to help their peers, both staff and students, to find the correct avenues of at least reaching out to people who can help them, such as our social worker, school psychologist, and/or counselors, our counselors in the counseling department."

Interestingly, and not unusual for principals, all of the participants seemed to go into "brainstorming" mode when responding to this particular question. Responses to this question tended to focus on the logistics that would be necessary in order to successfully roll out a mental health curriculum, including, but not limited to, time, money and funding and collaboration among different staff members. Responses suggested the current practices for implementing

mental health education, are divided up among multiple staff members. Current practices may not be effective, as three participants specifically expressed the desire, or need for, “someone to take on the work” or “someone who was strictly dedicated to this.”

Despite being asked to reflect on supports or resources available to them to make MHC implementation more feasible, three participants responded by first stating challenges or barriers that exist and then went on to discuss available or desired supports. One possible reason for this may be that it may be hard to immediately reflect on available supports, when the barriers are so glaringly obvious or have impeded the school from accessing supports, if any, in this area.

Interview Question 6

Interview question 6 asked "What are challenges to accessing and implementing a mental health curriculum in your school?". This question was designed to provide information regarding research question 4, 'What are the challenges to implementing a MHC in schools based on high school principals' perceptions?'. Similar to responses to Interview Question 5, logistics, cost, time, and access to resources were the main themes that emerged when analyzing participants responses to this question. According to Principal 2, “the number one challenge in public education a lot of times is just, especially in rural areas, the dollars just aren’t there sometimes and you have to get around that and get creative.” Responses also indicated that principals are aware that mental health does impact academic performance and how students “integrate and have a sense of belonging within the school” (Principal 1). Responses to this question also indicated that finding the time to implement a MHC would be very challenging. Principal 4 stated, “I think just finding the time to have that built into your program, built into the school day, that would be our biggest challenge.”

Participants alluded to the fact that selecting a MHC might be difficult and that buy-in from staff, students, and families would be critical. There was also skepticism about what programs to use. Principal 2 asked, “Which curriculum would we use? What’s going to best benefit students?” when reflecting on challenges of MHC implementation. Every participant noted money or funding as a challenge. Interestingly, one principal noted school closures related to COVID-19 as a potential barrier, stating the unknowns of next school year could be a hinderance when trying to implement a MHC.

Principal 1 st the need for a specific “body” or person to do the work and for consistent training for staff. Principal 1 recognizes that students do not always come forth when they are having a problem or are in stress, noting that in their experience, “It’ll either come from their friends or it’ll come from their teacher that they’re connected with, that they have a relationship with. So, in that sense, our teachers and our students also need to know the signs and know where to go to notify and get help.” This statement reflects the true need for an increase in not only student, but staff, mental health literacy.

Interview Question 7

Interview questions 7 asked, “Do you see a need for mental health curriculums in your school?”. The goal of this question was used to gauge the interest level of principals and to answer research question 3. The goal was to find out whether or not principals feel like mental health education is needed at their schools. Every respondent stated they feel there is a need for MHCs in their schools, with most participants noting that they have noticed an increase in the need for mental health education over time. Principal 2 began by stating, “Ah, yeah, absolutely. I think it’s consistently been on the rise” and noted that students of all grade levels could benefit

from more mental health supports within their school building. A simple “yes” was all that Principal 4 gave when responding to this question.

Principal 5 replied, “Absolutely. Students, I think, I don’t know if… One, I think there needs to be an understanding as to what is a mental health issue, like what exactly does that mean, by all points? And then two, dive into kinda how to identify and navigate. I’ve heard a lot of students say that they’re XYZ related to mental health when they’re, or you see their actions and you can’t help but to think like, something mentally is not lining up right now; they’re in crisis; they’re unstable. Just, by observing students’ behaviors, teacher reports, parent reports about—all the meetings I’ve been involved in in regard to SBIT, IEP meetings—talking about the levels of stress, anxiety, and all the different reasons why students are suffering in and out of school, as it relates to school. Definitely, there’s a need.”

Interview Question 8

Interview Question 8 asked, “If you had a magic wand, what would you wish for to help students increase their understanding of mental health?”. The purpose of Question 8 was to find out what principals would wish for to help students better understand mental health. The hope for this question was for participants to dream big, which is exactly what they did. Wishes included: making mental health education a course requirement, money, people, a great program or curriculum and explicit instruction, understanding and empathy from both staff and students, unlimited fun and unlimited time, appropriate training for staff, reducing the stigma around mental health, partnership with community-based resources, and home-school collaboration, possibly in the form of an educational outreach program to educate parents about mental health as well. Principal 5 started by saying, “I think the obvious thing is explicit instruction” and went on to explain how the students at their school are so driven towards college. This made Principal

5 wonder if students would actually want to take the time away from academic instruction to learn about mental health. Principal 5 also wished for a "partnership with someone outside of the school who is able to bring in some research and form the process as well."

Principal 1 began by stating, "If I had a magic wand, I would say that I would make that a course requirement." Principal 2 said, "Yeah, I mean if I had a magic wand I would ask for money and people." Principal 4 replied, "So, I guess with my magic wand it would be: the community involvement, figuring out what truly is needed within our community, the qualified instructors and just having the time in our day to hold that quality instruction."

Discussion

The Virginia Department of Education (VDOE) requires each school district in the state to teach their students about mental health. Specifically, it is suggested that this information be taught during Health classes. Additionally, all 9th and 10th grade students are required to take Health and Physical education classes. The current research suggests that adolescents know very little about mental health conditions and their accompany symptoms (Burns & Rapee, 2006; Hess et al., 2004; Jorm, Korten, et al., 1997; Jorm, Barney, et al., 2006; Meeks, 2018; Olsson & Kennedy, 2010). The current research also suggests that one means of addressing this lack of knowledge is through school-based interventions, such as implementation of a MHC. The purpose of this study was to gain insight into the current practices, if any, of MHC at the high school level.

Current Practices in MHC Implementation

Information gathered from Interview Questions 1, 2, 4, and 8 was used to answer Research Question 1, "What are the current practices for implementing Mental Health Curriculum's (MHC) in schools based on high school principal's perceptions?" When asked this

question, Principal 2 stated, “We don’t, we don’t have any. Our guidance counselors do, you know, go around and talk about that [mental health] some. And of course, in our physical education where we have a health component and it’s talked about some, but a full-scale mental health curriculum is not implemented.”

Five out of five principals contacted for this study reported their schools do not currently implement or use any kind of mental health curriculum. Based on the responses gathered for this study, it appears that many high schools are using piecemealed lesson plans as a means of mental health education versus using an evidence-based curriculum. Using a piecemealed lesson plans is problematic, because not only is there no data to suggest whether or not the information presented is accurate, there is also not a way to systematically assess students pre and post knowledge to determine whether or not the lesson plans are serving the intended purpose. Best practice in schools is to use evidence-based curriculums.

While none of the principals explicitly stated that students at their school are unable to recognize the symptoms of mental health conditions, and based on the current literature, it is likely students have limited mental health literacy based on the current practice of MHC implementation reported by the principals in this study. As Burns and Rapee (2006) stated, “The ability of adolescents to ‘label’ depression is not just an academic exercise. It is likely to increase a young person's urgency for seeking help and who they seek help from.” The information from the present study suggests that principals would not only benefit from being informed on best practices in mental health education, they would also benefit from explicit instruction on current and researched-based MHC to gain a better understanding of the true value of MHC.

Overall, the involvement level of principals in regard to MHC implementation, or involvement of mental health activities, of varied quite a bit. ‘Moderately or Very Involved’

participants (n=2) went into great detail about school-wide initiatives or ways in which they have attempted to alleviate or address mental health concerns within their building. The responses from this study suggest that despite level of involvement in activities regarding student mental health education, all principals see the need for supporting students in this area. These findings also suggest that at times, principals are responsible for hiring and coordinating a team of staff to focus on student mental health, leaving most of the planning and implantation up to the other members. This information reinforced the need to educate principals on best practices in mental health education and MHC implementation. Additionally, the results from this limited sample suggest that current practices are fragmented and limited in addressing the VDOE mandate for mental health education.

Interest Level

Interview Question 7 was used to answer Research Question 2, "What is the interest level of high school principals in implementing MHC?" and was intended to gauge the interest level of participants. The responses to this item overwhelmingly support the need for MHC in high schools, with one participant stating, "But yes, I would be completely open to having a curriculum here." Principals responses were consistent with the current literature which states that mental health concerns are on the rise, specifically for children and adolescents. Psychoeducation provides students with the information and tools they need to not only recognize the symptoms of mental health conditions, but to also appropriately seek help for these symptoms.

Due to the nature of the administrative role, there may be some uncertainty of the level of interest from administration in regard to the value of MHC. Based on the responses in this study, principals have a strong interest and recognize the need for mental health support but appear

limited in knowing how to move forward for implementing services. The information from this study suggests that principals would benefit from explicit information on how to roll-out and implement MHC's in their school. Providing high school principals professional development opportunities in the area of mental health education, as well as, providing them with research-based curriculums that could be implemented in their schools is warranted.

Two principals discussed their schools use of school-climate surveys for identifying and targeting student mental health and well-being. Utilization of school-climate surveys is one way to help aid principals in understanding student and staff well-being in their schools. For example, Principal 5 stated that the results of a school-climate study showed that there were concerns about student's mental health in regard to the amount of homework they are taking home and if they one, get enough sleep and two, have time for things they like to do outside of school. One way they tried to address this within their specific school was by collaborating with teachers and then working within the confines of the division homework policy with the hopes of improving student mental health. Information from several principals suggested that at times, systems and building level change is necessary to address both student mental health and mental health literacy.

Supports

Interview Questions 3 and 5 were presented to participants to answer Research Question 3, "What facilitates or supports implementation of MHC in schools based on high school principals' perceptions?". Administration, Director of Guidance and School Counselors were the only commonalities among responses, with each role being brought up by two of the participants. Other responses included: Secondary Supervisor, PBIS Coordinator, Director of Pupil Services and School Psychologist, which were each only mentioned by one participant. Participants

responses to Question 3 indicated that collaboration would be necessary for successful implementation of MHCs in their schools. Responses to this question also alluded to the fact that principals may not be aware of the skillset and relevance of school psychologists when it comes to MHC, as most responses suggested they would work with the school counselors and guidance department and only one participant stated they would contact the school psychologist for help in implementing a MHC.

In 2018, mental health education became a mandated topic in grades nine and 10. Principals should keep this in mind and use it to their advantage when looking for support and resources form their divisions in regard to MHC implementation. MHC not only provide students with accurate, and up to date information, they also provide a way to assess students knowledge and mental health literacy. Additionally, including mental health education in schools legitimizes the topic and educational value of mental health, normalizes discussion around it, and reduces the stigma (Kutcher, Wei, & Bullock, 2013). There is also evidence to support the feasibility of mental health literacy interventions, suggesting it is highly feasible in schools (Pinto-Foltz, Logsdon, & Myers, 2011). This information will be helpful in addressing principals' concerns relating to staff buy-in and time constraints.

Barriers

Interview Question 6 was used to answer Research Question 4, "What are the challenges to implementing MHC in schools based on high school principals' perceptions?". Participants in this study expressed a strong desire and need for MHC in their schools. All principals expressed a great understanding of the need for mental health supports within their schools and acknowledged that many barriers exist. Thus, the gap between the need for MHC in high schools and the desire to implement them needs to be addressed. Cost of programming and funding were

mentioned several times when discussing the barriers to accessing MHC. There are several free MHC available, including The Adolescent Depression Program (ADAP) and Teen Mental Health. Every principal stated they do not use a specific MHC, perhaps because they did not know they exist. One way to address the gap between the need and desire for MHC is by simply bringing awareness to the free MHC that exist. The results from this study indicate that principals are also concerned about the relevancy of the curriculum to their school and wondered how to pick an appropriate curriculum. Principals could use a school-climate survey to first understand where more support is needed in their schools in regard to mental health. They could then research a MHC which would address this specific area of need.

Time and staff buy-in were also addressed as barriers during this study. When studying the effects of a specific MHC, Milin and colleagues found that teachers were easily able to easily integrate the material into their existing course and implementation was very successful (2016). Additionally, the teachers who delivered the curriculum reported having an overall positive experience. There is also evidence to suggest that participation in teacher training programs focused on proper delivery of MHC in classrooms is highly regarded and impactful for teachers (Kutcher, Wei, McLuckie, & Bullock, 2013). Many MHC are short and to the point—some only requiring two or three class periods to cover the material. Presenting the material as a two-day lesson to teachers versus a whole curriculum may be one way of securing administrator and staff buy-in. Additionally, it will be important to share with teachers that delivering the material will help staff to become more adept at recognizing student who are in distress, a skill many of the principals reported they wished their staff members had during this study.

Additional Information

While Interview Question 8 (“If you had a magic wand, what would you wish for to help students increase their understanding of mental health?”) was used in part to answer Research Question 1, it was also asked to gain an understanding of future perspectives and hopes for mental health literacy education in high schools. The responses indicated a strong desire for the resources to properly invest in mental health education and to further students’ knowledge in this area as best they can. Several principals indicated they do not feel like students always seek help when they are in distress. The responses indicate that principals genuinely care, and are concerned about, the mental well-being of the students in their schools. There are currently adolescents who are suffering from symptoms of a mental health condition, but are not receiving treatment. One suggestion for closing this gap is by increasing student mental health literacy. When discussing MHC with principals, it will be important to share that MHC will help facilitate appropriate help-seeking behavior of their students.

The value of mental health literacy is not only being able to recognize the symptoms of mental health conditions, but also learning when, where, and how to seek appropriate help. By implementing MHC, principals will likely see an increase in students seeking help for themselves or for a peer. It is therefore imperative that schools advocate for mental health resources and supports within their schools and school divisions. Additionally, advocating for more school psychologists, school counselors, and school social workers is one way to support the increase in student referrals.

Though not all students will experience symptoms severe enough to be considered clinically significant while in school, all students do have mental health and wellness, and could potentially experience this later on in life. Implementation of MHC not only acts as an

intervention tool for students who are currently experiencing symptoms, but it also serves as a preventative measure for students who may experiences symptoms or notice them in a friend after learning the material. Additionally, MHC often references ways in which students can engage in self-care or manage their symptoms and reduce stress. These coping-skills are useful for all students, as all students experience stress at some point or another.

At one point during the interview, Principal 4 stated, “I don’t think the state would be able to take one specific curriculum and say, “Okay, use this throughout the state” because I feel that that would probably be too narrow focused and because each area would need to have their own specifics of a program of some sort.” There is definitely truth in this statement and it will be important for principals to collaborate with other staff, such as school psychologists and counselors, to determine which MHC will be most appropriate for their school. Principal 4 went on to say, “I really feel like each individual attendance district should have the opportunity to choose because I feel like even it was a box unit or box something, curriculum, that’s given to the schools, one size doesn’t fit all when it comes to mental health.” This response indicated a desire for there to be some flexibility when it comes to addressing mental health at the building level.

Limitations

There are a number of limitations to the present study. In regard to the data analysis, only the researcher was responsible for coding responses into themes. For future studies on this topic, it might be more appropriate to have multiple coders to ensure there is a general consensus upon themes and for reliability purposes.

In regard to methodology, first, due to school closures and COVID-19, the researcher had to quickly redesign and alter the study, thus creating the 8-question, semi-structured interview

used in this study. Therefore, due to time constraints, the interview questions do not thoroughly reflect or investigate all aspects of mental health curriculum implementation at the high school level. Notably, upon review, the researcher feels that the interview questions may not fully capture principals' true interest level in regard to implementing MHC, as participants were not directly asked if they have an interest in implementing a MHC at their school. Though participants did express interest and were in support of future MHC implementation in their schools, Research Questions 2 may not fully be answered by this study alone. More research on principals' interest level seems warranted.

Second, mental health curriculums are currently few and far between. It is possible that the participants interviewed may not have heard or used the specific terminology "mental health curriculum" prior to participation in this study. More research around the correct terminology for curriculums designed to increase mental health literacy may be warranted. Additionally, it is also possible that due to the small sample size and nature of convenience-sampling, the opinions, ideas and experiences of participants may not be reflective of all high school principals. Third, to the researcher's knowledge, there are no journal articles that currently exists on mental health curriculum implementation and specifically, the experiences of high school principals with MHC.

This study is just the tip of the iceberg and many more studies and research methodologies are necessary in order to better understand the need for, and implementation of, MHC's at the high school level. Future research could include connecting participants to their professional backgrounds for a better understanding of their experiences. In hindsight, it may have been more appropriate to investigate principals' knowledge of mental health literacy, before investigating their knowledge of mental health curriculums specifically. In the future, it will be

necessary to inform and educate school principals on the topic of mental health, specifically mental health literacy, as well as provide them with ideas and resources for how to increase mental health literacy. These conversations could then shift and begin to focus on educating principals and providing them with best practice resources for mental health curriculum implementation at their schools.

Implications for School Psychologists

When it comes to mental health literacy in schools, there are a number of implications for school psychologists. To start, school psychologists are trained to understand how mental health impacts a student's ability to be successful within the classroom and at school. In addition to being trained in individual and group counseling, assessment, behavior and classroom management, and consultation, school psychologists are trained in education law and curriculum and instruction (NASP, 2015). This means that school psychologists would be an excellent resource for school principals when it comes to MHC implementation.

Early intervention is critical in many realms within schools and mental health is no exception. Ideally, mental health education will continue to grow and evolve and eventually occur at all grade levels, but for now, 9th and 10th grade, especially in Virginia, are a good place to start. School psychologists will be instrumental in making this a reality. As the field as a whole continues to advocate for more support and school psychologists within the schools to address the mental health needs of students, consider implementing a MHC in the meantime. MHC are cost-effective, evidence-based, and often times time-friendly. There are several MHC that exist which are completely free to school districts. In speaking with principals for this study, it was clear that many of them would like guidance and support in order to find and access MHC that would be appropriate for their school and students. School psychologists can, and should, make

themselves available to lead or assist professional development opportunities to inform their districts about mental health education, as well as, provide recommendations for appropriate curriculums.

Time constraints and resources were two factors that constantly echoed throughout the responses provided by each principal in this study. Many stated they would love for there to be a designated person or role for facilitating and rolling out a mental health curriculum. School psychologists are excellent candidates for this work and many would embrace the opportunity to do so. Despite their skills not always being well recognized by staff within their schools, school psychologists are very well-trained and passionate about student mental health. However, mental health is considered a sensitive topic and it can be taboo to talk about it. Unfortunately, many people worry about the negative stigma that society has unnecessarily attached to mental health. As school psychologists, it is extremely important to try and shift this way of thinking. One way this can be done is by advocating for your schools to begin implementing evidence-based MHC, similarly to the way we advocate for updated test kits and intervention materials. Everyone has mental health and it is extremely important that we create a script, especially in schools, that knowledge of mental health is critical to the academic success and well-being of students.

Conclusion

This study offers a brief insight into the current practices of mental health curriculum implementation at high schools in Virginia. By better understanding the supports and barriers that are faced by principals and assistant principals when implementing MHC, we can begin to find ways to make MHC more accessible and feasible for all schools. The responses in this study are consistent with what we know about child and adolescent mental health—mental health conditions, like anxiety and depression, are on the rise within our schools and the need for

mental health education and use of MHC designed to increase students' mental health literacy, is warranted.

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Appendix A

Interview Questions

1. What mental health curriculum(s), if any, does your school implement?

2. How have you worked with staff to implement mental health curriculums in your school?

3. Who would you contact from your school to find and implement a mental health curriculum?

4. Explain any exposure you have had to specific mental health curriculums (e.g. conversations with school staff)

5. What supports or avenues do you have in your schools to help make mental health curriculums more feasible or accessible to students?

6. What are challenges to accessing and implementing a mental health curriculum in your school?

7. Do you see a need for mental health curriculums in your school?

8. If you had a magic wand, what would you wish for to help students increase their understanding of mental health?

Appendix B

Script for Recruitment of Participant's for Jacqueline Billy's Research Project

"Jacqueline Billy is currently an Ed.S. candidate at James Madison University. Completing a thesis project is one of the requirements for an Ed.S. degree. Jacqueline is looking for **6-12 high school principals and assistant principals in Virginia to interview in regard to their experiences with implementing mental health curriculum's in schools** for her thesis project.

The purpose of Jacqueline's study is to add to the limited literature on accessibility of, and barriers to, implementing mental health curriculums in high schools through the eyes of school principals and assistant principals. The information will be used to inform school psychologists on how to have conversations with principals and to be informed on the implementation of mental health curriculums.

Do I have your permission to share your contact information with Jacqueline? If you agree, she will reach out to you to schedule a 20-minute interview.

If you would like to reach out to Jacqueline yourself to inquire about the study and the possibility of being a participant, she can be reached at billyjm@dukes.jmu.edu."

Appendix C

VERBAL CONSENT DOCUMENTATION FOR PARTICIPATION.

SUBJECT: An Exploration of High School Principals' and Assistant Principals' Perceptions of Implementing Mental Health Curriculums in High Schools

Oral consent serves as an assurance that the required elements of informed consent have been presented orally to the participant or the participant's legally authorized representative.

Verbal consent to participate in this telephone survey has been obtained by the participant's willingness to continue with the telephone survey by providing answers to a series of questions related to the participant's experience with implementing mental health curriculums (MHC) in schools.

You are being asked to participate in a research study conducted by Jacqueline Billy from James Madison University. The purpose of this study is to add to the limited literature on accessibility of, and barriers to, implementing mental health curriculums in high schools through the eyes of school principals. The information will be used to inform school psychologists on how to have conversations with principals and to become more informed on the implementation of mental health curriculums.

This study consists of an interview that will be administered to individual participants over the telephone. You will be asked to provide answers to a series of questions related to your experiences with implementing mental health curriculums in high schools.

Participation in this study will require about 20 minutes of your time.

We do not perceive more than minimal risks from your involvement in this study (that is, no risks beyond the risks associated with everyday life).

While there are no direct benefits to the participant for participating in this study, potential benefits from participation in this study include adding to the limited body of literature that exists on mental health curriculums in high schools, specifically through the eyes of a high school principals.

The results of this research will be presented at a conference. The results of this project will be coded in such a way that the respondent's identity will not be attached to the final form of this study. We retain the right to use and publish non-identifiable data. While individual responses are confidential, data will be presented in aggregate form. All data will be stored in a secure location accessible only to us, the researchers. Upon completion of the study, all information that matches up your with your answers, including audio recordings, will be destroyed.

Your participation is entirely voluntary. You are free to choose not to participate. By agreeing to participate in this study, you are asserting that you are at least 18 years old. Should you choose to participate, you can withdraw at any time without consequences of any kind.

Do you have any questions about the study, your participation, or your rights as a participant?

Do you give consent to be audio recorded during your interview?

I attest that the aforementioned written consent has been orally presented to the human subject and the human subject provided me with an oral assurance of their willingness to participate in the research.

Surveyor's Name (Printed)	Surveyor